IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

WILLIAM C. JACKSON,	:	
	:	
Plaintiff,	:	
	:	
v.	:	CIVIL ACTION
	:	NO. 02-4458
JO ANNE BARNHART,	:	
COMMISSIONER OF SOCIAL	:	
SECURITY,	:	
	:	
Defendant.	:	

Giles, C.J. August 1, 2003

MEMORANDUM

Introduction

William C. Jackson originally filed an application for Social Security Disability benefits on August 24, 1998, alleging an onset date of disability as August 5, 1998. The application was denied. He then sought reconsideration of his application and again was denied. Thereafter, on December 14, 1998, he filed a timely request for a hearing before an administrative law judge ("ALJ"). A hearing was held on June 10, 1999, and testimony was taken from plaintiff and a vocational expert. However, the case was remanded to the state agency for evaluation of a newly alleged mental impairment, not previously addressed by the agency.

A second reconsideration hearing was denied on September 18, 1999. Plaintiff filed a request for another hearing on October14, 1999. The second hearing was held on February 7, 2000 with the original ALJ. Additional testimony was taken from the plaintiff. On May 30, 2000, the ALJ issued a decision finding him "not disabled." Plaintiff filed a request for review of the ALJ decision with the Appeals Council on June 2, 2000. On April 30, 2002, the Appeals

Council declined to review plaintiff's claim, thereby rendering the ALJ's decision the final decision of the Commission. Plaintiff then filed this action, pursuant to the Social Security Act, 42 U.S.C. § 405 (g), seeking to have the decision of the Commissioner reversed and remanded for the calculation of benefits, or in the alternative, to have the matter remanded for further administrative proceedings in compliance with established Third Circuit law.

Having considered the cross motions, the Court reverses the decision of the ALJ. For the reasons that follow, the Plaintiff's Motion for Summary Judgment is granted and the Defendant's Motion for Summary Judgment is denied.

Facts

Plaintiff was born on April 7, 1950. He lives with his mother, wife and daughter and has received his GED. Plaintiff was employed by the Philadelphia Fire Department as a stock clerk from 1997 to 1998. Before his employment with the fire department, plaintiff was employed by the Philadelphia Police Department, also as a stock clerk, from 1971 to 1997. On July 12, 1997, plaintiff's back was injured at work while he was lifting fifty pound bags of an oil absorbing product. He left work experiencing pain.

Plaintiff was sent to Allegheny University Hospital by his employer. He sought medical treatment there the following day. (R. 271). Plaintiff underwent a CT Scan on July 15, 1997, which showed at L4-L5 of the lumbar column mild foraminal narrowing on the left side. (R. 267). The thecal sac was minimally symmetric, wider on the right than the left, and no obvious disc herniation was present. Id. The report indicated that the examination was limited due to the patient's large size and a MRI scan was recommended, particularly with respect to the L5-S1 junction. Id.

On July 22, 1997, plaintiff was evaluated again at Allegheny Hospital. He was advised by the treating physician to return to work on "transitional duty" and was restricted to carrying no more than ten pounds, to sit frequently and remain stationary, and to change positions as needed. (R. 132). Plaintiff sought a second opinion and was evaluated by Dr. Balasubraman, M.D., an orthopedic surgeon. (R.137-139). Dr. Balasubraman's treatment notes indicate that plaintiff was experiencing significant pain. (R. 140). On Dr. Balasubraman's instructions, plaintiff underwent a MRI scan. Id.

Plaintiff was also evaluated by Dr. Schnibben, M.D., who concluded that plaintiff could return to work immediately but was restricted to "light duty" of four-hour shifts, with two to four hours of either sitting or walking, and was limited to lifting no more than ten pounds. (R. 154). Dr. Schnibben's treatment notes indicate that the plaintiff experienced significant pain after 3-4 hours of working "light duty." (R. 206).

Plaintiff later underwent a MRI as ordered by Dr. Balasubraman. The MRI revealed that plaintiff had a herniated disc[1] at the L5-S1 level, with indentation of the thecal sac. (R. 175). Upon review of the MRI results, Dr. Balasubraman recommended that plaintiff perform "no duty." (R. 155). His treatment notes reveal that plaintiff was then still experiencing significant pain, and he prescribed medication and physical therapy. Id.

On August 8, 1997, plaintiff visited his family physician, Dr. Yeoman. His notes indicate that plaintiff was still experiencing pain and that the medication prescribed by Dr. Balasubraman was not helping. (R. 273). Dr. Yeoman prescribed Percocet. Id. Plaintiff's physical therapist

---

[1] Protrusion of the nucleus pulposus or annulus firbrosis, which may impinge on the nerve roots. Richard Sloane, The Sloane-Dorland Annotated Medical-Legal Dictionary 344 (West 1987).

reported that he did not appear to be benefitting from physical therapy as he was suffering from increased pain and decreased function. (R. 174).

On October 13, 1997, nerve conduction studies were performed. They showed no nerve damage. (R. 180). At the request of Dr. Balasubraman, plaintiff sought a second opinion from a neurosurgeon, Dr. O'Connor, M.D. (R. 148). Dr. O'Connor opined that plaintiff's back injury did not indicate any nerve root or thecal sac compression. (R. 185). However, he did recommend a second MRI scan to further evaluate plaintiff's injury. Id. The second MRI showed findings consistent with L5-S1 disc herniation. (R. 191).

On August 19, 1997, plaintiff again saw Dr. Balasubraman. (R. 157). Dr. Balasubraman's notes indicated that plaintiff was mildly better but that the plaintiff was still experiencing pain. (R. 168). As a result, he prescribed Naprosyn, an anti-inflammatory, and again recommended that plaintiff perform "no duty." (R. 157). Another follow-up appointment took place on August 29, 1997. (R. 156). Plaintiff indicated that he was experiencing worse pain in the front of his legs and the daily dosage of Naprosyn was increased. Id. Plaintiff was recommended for "no duty" through September of 1997. (R. 153, 152, 150). Thereafter, Dr. Balasubraman stated that plaintiff was able to return to work with limitations. Plaintiff was not to lift more than twenty pounds, and fewer than six times per hour. (R. 149). On October 28, 1997, Dr. Balasubraman recommended that plaintiff work only four hours per day for three weeks. (R. 147). The four-hour work day limitation and work restrictions continued through at least June 30, 1999. These limitations were adopted by Dr. Schnibben, who examined plaintiff from March 1998 through June of 1999. (R. 238).

The state agency conducted a Residual Function Capacity (RFC) for the plaintiff. (R.

114-121). The state medical consultant, *without examination*, made the following conclusions: (1) plaintiff could occasionally lift 100 pounds or more and frequently lift fifty pounds or more; (2) plaintiff could sit, stand or walk for six hours of an 8-hour work day with normal breaks; (3) no postural or manipulative limitations existed; and, (4) plaintiff could push or pull in an unlimited capacity. Id. During the same time period, Dr. Schnibben, *with examination*, was recommending that plaintiff: (1) lift no more than twenty pounds; (2) stand or walk for two hours, kneel for one hour, bend for one hour, sit for four hours, and squat for one hour with no overhead work; (3) wear a brace while working; and, (4) work only a four-hour day. (R. 205-206, 212-213).

Dr. Gary Yeoman, D.O., also treated plaintiff after his injury and during the relevant time period. Dr. Yeoman saw the plaintiff on a number of occasions, primarily from the time of his injury through November of 1999. (R. 239). Plaintiff was treated by Dr. Yeoman for back injury and for depression. Id. Plaintiff stated that as a result of his injury he could only work limited hours, later could not work at all, and as a result was evicted from his home, requiring him to move in with his mother. (R. 284) Dr. Yeoman's treatment notes show that plaintiff had a lack of interest and motivation, and could not maintain focus on tasks. (R. 263-264). There also were a number of deaths in the plaintiff's family. Id. These events contributed to his depressed state. Id. As a result, Dr. Yeoman prescribed antidepressants. Id.

On May 28, 1999, Dr. Yeoman completed a residual functional capacity questionnaire for the plaintiff. (R. 239). Dr. Yeoman diagnosed the plaintiff with fatigue[2], depression, sleep

[2]Fatigue is characterized by a feeling of weariness, tiredness or lack of motivation, drowsiness and apathy. U.S. Library of Medicine, Medical Encyclopedia at http://www.nlm.nih.gov/medlineplus/ency/article/003088.htm (last updated Nov. 18, 2002).

apnea, hemangiolipoma, herniated lumbar disc L5-S1, and foraminal stenosis of L4-L5. Id. The questionnaire shows a prognosis of recovery from chronic depression as being fair, and chronic back pain as being poor. Id. Dr. Yeoman further noted that plaintiff had pain in the lower lumbar area, and that the pain radiated to bilateral thigh and groin areas. Id. He also experienced pain on standing that was severe without medication. Id. The doctor indicated that the pain was at the moderate/severe level. Id. In Dr. Yeoman's opinion, pain frequently interfered with plaintiff's attention and concentration, and that plaintiff's conditions severely limited his ability to deal with work stress. (R. 214). The questionnaire further noted that the plaintiff could walk only one city block without rest, could sit for only fifteen minutes and twenty minutes at a time, and in an eight-hour day could sit, stand or walk for less than two hours. Id. Moreover, Dr. Yeoman opined, based upon his evaluation, that plaintiff's condition would require him to be absent from work more than three days per month. Id.

On August 24, 1999, at the request of the ALJ, plaintiff was also evaluated by Dr. Jerry Kear, Ph. D. He diagnosed plaintiff as having dysthymic disorder[3], noting that his depression was a result of his physical pain. (R. 245). Dr. Kear opined that plaintiff's prognosis was fair, that the prospects of improvement were not very good at the time, and that a quick result was unexpected. Id. Dr. Kear also noted that the plaintiff could get things done within a schedule if not in too much pain but that he could not perform very long before experiencing pain. Id. Dr. Kear also stated that plaintiff could make some decisions, that his attention span drifted, and that

[3]Dysthymic disorder is characterized by a chronic depressed mood accompanied by two or more of the following: poor appetite or overeating; insomnia or hypersomnia; low energy or fatigue; low self-esteem; poor concentration; difficulty making decisions; or hopelessness, and can cause impairment of social or occupational function. Diagnostic and Statistical Manual of Mental Disorders 376 - 380 (4th ed. 2000).

plaintiff could understand, retain and follow simple, but not complex instructions. Id. Dr. Kear did not opine that plaintiff could maintain regular attendance, job persistence or pace in competitive employment.

Lastly, plaintiff completed a "Daily Activities Questionnaire" form on August 6, 1999. (R. 91). Plaintiff reported that he had difficulty putting on his socks and shoes and needed help getting out of chairs when his back was inflamed. Id. He also stated that he could not watch television or complete puzzles because he could not sit for an extended period of time. Id. Further, he could not go shopping as he could not lift bags or walk around the store. Id. He also could not cook or do household chores because he could not stand for an extended period of time. Id. He stated that he could drive only short distances but only if he did not take the pain medication. Id.

The plaintiff testified at the administrative hearing that as a result of his back pain and the side effects of his medication, he sometimes could not finish his four-hour shifts. (R. 300-301). He stated that he also missed up to six days of work per month while on light duty because of the pain that he experienced. Id. He also testified that he continued to experience severe back pain, preventing him from working. Id. A vocational expert testified that a person with the plaintiff's exertional limitations could perform light work but only if that individual was able to maintain regular attendance, concentration, task persistence and pace; otherwise, the job base would be completely eroded and no jobs in the economy would exist. (R. 304-305). He did not opine that plaintiff possessed these essentials for light work.

ALJ Findings

In determining whether a claimant is eligible to receive disability benefits, the ALJ

utilizes a five-step analysis:

> First, the Commissioner considers whether the claimant is currently engaged in substantial gainful activity. If he is not, then the Commissioner considers in the second step whether the claimant has a "severe impairment" that significantly limits his physical or mental ability to perform basic work activities. If the claimant suffers a severe impairment, the third inquiry is whether, based on the medical evidence, the impairment meets the criteria of an impairment listed in the "listing of impairments," 20 C.F.R. pt. 404, subpt. P, app. 1 (1999), which result in a presumption of disability, or whether the claimant retains the capacity to work. If the impairment does not meet the criteria for a listed impairment, then the Commissioner assesses in the fourth step whether, despite the severe impairment, the claimant has the residual function capacity to perform his past work. If the claimant cannot perform his past work, then the final step is to determine whether there is other work in the national economy that the claimant can perform. The claimant bears the burden of proof on steps one, two, and four of this test. The Commissioner bears the burden of proof for the last step.

Sykes v. Apfel, 228 F.3d 259, 262-263 (3d Cir. 2000). Here, the ALJ found that plaintiff met the disability insured status requirements on August 5, 1998, and had not engaged in any substantial gainful activity since that date. (R. 17). The medical evidence established that plaintiff had severe musculoskeletal and mental impairments. Id. However, the ALJ found that at all relevant times the plaintiff did not have an impairment which met or medically equaled any listed impairment. (R. 18). The ALJ also concluded that, although plaintiff's testimony was generally credible regarding his limitations, his limited activities of daily living did not alone support his assertion of total disability. Id. The ALJ found that the medical evidence supported a finding that plaintiff was precluded from prolonged standing and walking, required a sit/stand option, and was limited to simple one and two step tasks. Id. Yet, the ALJ found that these limitations did not preclude plaintiff from lifting up to twenty pounds with frequent lifting and carrying

weights up to ten pounds. Id. Consequently, the ALJ concluded that plaintiff was capable of performing a significant number of jobs in the national economy and therefore was not "disabled" as defined by the Act. Id.

In making these determinations the ALJ attached no weight to the opinion of plaintiff's treating physician, Dr. Yeoman, discredited the state agency medical reviewers, and discounted the opinion of plaintiff's second treating physician, Dr. Schnibben. (R. 14-15).

Standard of Review

In reviewing an ALJ's decision, the court must determine whether the decision is supported by substantial evidence of record. Sykes, 228 F.3d at 262. Substantial evidence is "more than a mere scintilla," and "such relevant evidence as a reasonable mind might accept as adequate." Burnett v. Commissioner of SSA, 220 F.3d 112, 118 (3d Cir. 2000) citing Plummer v. Apfel, 186 F.3d 422, 427 (3d Cir. 1999). Even if the record could support a contrary conclusion, the decision of the ALJ will not be overturned as long as there is substantial evidence to support it. Simmonds v. Heckler, 807 F.2d 54, 58 (3d Cir. 1986). The court's review of legal issues is plenary. Sykes, 228 F.3d at 263.

Analysis

The Court finds that the ALJ erred by failing to accord appropriate weight to plaintiff's treating physicians, substituting her own lay opinion for that of medical experts, and failing to adequately assess plaintiff's subjective complaints.

A. The ALJ failed to assign adequate weight to the opinions of plaintiff's treating physicians.

In making a disability determination, "the ALJ must consider all of the evidence and give some reason for discounting the evidence she rejects." Plummer 186 F.3d at 429. When there is

a conflict in the evidence the ALJ "cannot reject evidence for no reason or for the wrong reason." Id. The Third Circuit has stated, "where there is conflicting probative evidence in the record, [there is] a particularly acute need for an explanation of the reasoning behind the ALJ's conclusions, and [the court] will vacate or remand a case where such an explanation is not provided." Fargnoli v. Massanari, 247 F.3d 34, 42 (3d Cir. 2001).

Moreover, the opinion of a treating physician is to be afforded great weight unless it is unsupported by medically acceptable clinical and laboratory techniques or is inconsistent with other substantial evidence of record. 20 C.F.R. § 404.1527(d)(2) (2002). This is because a claimant's treating physicians "are likely to be the medical professionals most able to provide a detailed, longitudinal picture of [the claimant's] medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations . . ." Fargnoli, 247 F.3d at 43.

Thus, "an ALJ may reject a treating physician's opinion outright only on the basis of contradictory medical evidence." Plummer, 186 F.3d at 429. It is established third circuit law that an ALJ may not reject a treating physician's opinion based on his or her own lay opinion or judgment in making disability determinations. Morales v. Apfel, 225 F.3d 310, 317-318 (3d Cir. 2000) citing Plummer, 186 F.3d at 429; Frankenfield v. Bowen, 861 F.2d 495, 408 (3d Cir. 1988); Kent v. Schweiker, 786 F.2d 110, 115 (3d Cir. 1983).

(1) The treating physician's opinion was not inconsistent with his prior opinion or with his treatment notes.

The ALJ's conclusion that Dr. Yeoman's treatment notes and earlier opinion were inconsistent with his May 1998 opinion is not supported by substantial evidence of record. The ALJ merely noted that on May 29, 1999, Dr. Yeoman's notes indicated that plaintiff suffered

constant bilateral thigh pain, but that in June of 1998, his treatment records indicate only occasional pain. However, Dr. Yeoman treated the plaintiff every three months from the date of his initial injury, a span of two years. Throughout that time period, the doctor's treatment notes make reference to plaintiff's "chronic back pain" and thigh and groin pain. The record also showed that plaintiff required Darvocet and Percocet multiple times per day to relieve the pain in his back and legs and that, dating back to 1997, plaintiff was treated for pain associated with his back injury. The plaintiff did not positively respond to physical therapy. His pain increased and his functionality diminished.

Further, Dr. Schnibben, plaintiff's other treating physician, noted that plaintiff suffered from chronic lower back pain that radiated to the thigh and groin area. This evidence was not addressed by the ALJ.

The long-term observations of Dr. Yeoman provided the "longitudinal picture" of the plaintiff's condition that the regulations require. See Fargnoli, 247 F.3d at 43. However, the ALJ concluded on the basis of asserted inconsistencies that Dr. Yeoman's entire medical opinion was accorded no significant weight.[4]

Similarly, the ALJ's reliance upon Dr. Yeoman's treatment notes of July 9, 1999, as an indication that the plaintiff's depression was improving, was improper. On May 21, 1999, Dr.

---

[4]The ALJ also found Dr. Yeoman's testimony that plaintiff suffered from fatigue, which limited the amount of time he could stand and sit, inconsistent with his treatment records, which showed no mention of fatigue. However, the plaintiff stated, upon questioning by the ALJ, that the medications he was taking made him drowsy. On a number of occasions, the plaintiff also stated that he was unable to perform certain tasks because he could not sit, stand or walk for long. Drowsiness is a common side effect of pain medications and fatigue is a symptom of plaintiff's mental condition, dysthymia. See supra. FN 2. Dr. Yeoman's opinion that plaintiff was fatigued was consistent with his treatment notes and with the objective medical evidence of record.

Yeoman indicated that plaintiff was depressed with no interest, a decreased appetite, and an inability to focus on tasks. Dr. Yeoman then increased the dosage of plaintiff's antidepressant medications. On the following visit on July 9, 1999, the date that the ALJ cites to as evidence of inconsistency, Dr. Yeoman's notes show that the plaintiff was less depressed on the increased dosage. However, on November 3, 1999, Dr. Yeoman's treatment notes show a marked increase in plaintiff's depression. Again, the ALJ's finding of inconsistency is not supported by the record. In doing so, the ALJ substituted lay opinion as to the significance of the temporary improvement for the opinion of a medical expert as to long-term recovery or lack thereof.

(2) The treating physician's opinion was not contradicted by credible medical evidence of record.

A treating physician's opinion can be rejected outright only in the face of contrary medical evidence. Plummer, 186 F.3d at 429. According to applicable regulations, a treating physician's opinion is to be afforded great weight unless it is unsupported by appropriate medical techniques or is inconsistent with substantial evidence of record. 20 C.F.R. § 404.1527(d)(2).

There is no medical evidence of record that contradicts the opinion of Dr. Yeoman. Dr. Schnibben's notes also show that the plaintiff suffered from chronic lower back pain with occasional bilateral thigh pain. The opinion of the non-treating, non-examining state agency medical reviewer was not credited by the ALJ for obvious reasons.

(3) The ALJ improperly substituted her own lay opinion for the expert opinion of plaintiff's treating physician on the ultimate issue of plaintiff's ability to work.

It is established third circuit law that, while an ALJ may make credibility determinations, he or she may not reject a treating physician's opinion based on his of her own lay opinion or judgments. Morales 225 F.3d at 317-318.

The record shows that as a result of plaintiff's condition, he was unable to work more than four hours because he experienced a great deal of pain that rendered him unable to perform beyond that time frame. (R. 206, 300-301). After being placed on "no duty" by Dr. Balasubraman, plaintiff returned to work in a "light duty" capacity but struggled to complete a four-hour shift. The record is replete with references to the plaintiff's pain, fatigue, resting requirements, and intolerance levels for lengthy periods of sitting, standing and walking. The plaintiff also experienced fatigue as a side effect of the medication he was taking for his pain and depression.

Because there is evidence to support the opinion of Dr. Schnibben that plaintiff can only work four hours per day, the ALJ was not allowed to reject that opinion absent contrary medical evidence. Id. Dr. Schnibben is the only doctor other than Dr. Yeoman that treated the plaintiff in the relevant time period.[5]

Despite the expert medical opinions and plaintiff's testimony, which the ALJ determined to be generally credible, the ALJ concluded that the plaintiff's activities of daily living alone did not support a finding of total disability. This was clear error.

B. By failing to weigh appropriately the opinion of plaintiff's treating physicians, the ALJ failed to weigh appropriately plaintiff's subjective complaints.

Plaintiff correctly argues that the ALJ failed to accord sufficient weight plaintiff's subjective complaints and that the ALJ's finding that the plaintiff was not credible was not based on substantial evidence. The plaintiff points out that his ability to perform some activities, such as light cleaning that does not require heavy lifting, maintaining his residence, paying bills,

[5] Dr. Balasubraman treated plaintiff prior to Dr. Schnibben. He originally recommended that the plaintiff work only four hours per day.

home-schooling, and using public transportation, does not mandate a finding that he is not disabled.

An ALJ must evaluate the reported symptoms beyond the objective medical findings, as symptoms can suggest a greater severity of impairment than objective medical evidence alone can show. 20 C.F.R. § 404.1529(c) (2002). Abstention by the plaintiff from recreational or other daily activities is not required for a finding of disability. Smith v. Califano, 637 F.2d 968 (3d Cir. 1981). Even if the medical evidence does not support a plaintiff's subjective complaints of pain, the ALJ must give serious consideration to those complaints. Mason v. Shalala, 994 F.2d 1058, 1067 (3d Cir. 1993). If there is medical evidence to support a plaintiff's complaints of pain, "the complaints should be given great weight and may not be disregarded unless there exists contrary medical evidence." Id. When a claimant has a long history of work, his testimony about his work limitations should be accorded substantial weight. Dobrowolsky v. Califano, 606 F.2d 403, 409 (3d Cir. 1979).

Because the plaintiff was continually employed from 1971 to 1998, his testimony about his limitations should have been afforded substantial weight. Id. Moreover, when the ALJ improperly discredited the medical records of plaintiff's treating physicians, he deprived plaintiff of substantial medical evidence supporting his subjective complaints.

As a matter of law, given the record evidence, the court is compelled to find that the plaintiff was "disabled" as defined by the Social Security Act, 42 U.S.C. § 423(d), and that plaintiff is entitled to receive the Social Security Insurance benefits claimed.

An appropriate order follows.

IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF PENNSYLVANIA

WILLIAM C. JACKSON,	:	
	:	
Plaintiff,	:	
	:	
v.	:	CIVIL ACTION
	:	NO. 02-4458
JO ANNE BARNHART,	:	
COMMISSIONER OF SOCIAL	:	
SECURITY,	:	
	:	
Defendant.	:	

Giles, C.J. August __, 2003

JUDGMENT ORDER

AND NOW, this __ day of August, 2003, in consideration of Plaintiff’s Motion for Summary Judgment, Defendant’s Motion for Summary Judgment, and the record, it is hereby ORDERED that:

i. Plaintiff’s Motion for Summary Judgment is GRANTED;

ii. Defendant’s Motion for Summary Judgment is DENIED;

iii. Judgment is entered in favor of Plaintiff and against Defendant.

BY THE COURT:

_____

JAMES T. GILES C.J.

copies by FAX on

to